Henderson County Department of Public Health
1200 Spartanburg Hwy Suite 100
Hendersonville, NC 28792
Tel 694-6015 Fax 697-4504

Foreign Travel Program Patient Record

Name: _____ Date of Birth: _____ Age:____

`Insurance: _____

Address: _____ TEL: _____

PATIENT QUESTIONNAIRE

ITINERARY: List the place(s) you will be visiting		**Date arrival/Date departure for each city if known**
Country:	**City:**	**__/__/__ to __/__/__**
Country:	**City**	**__/__/__ to __/__/__**
Country:	**City:**	**__/__/__ to __/__/__**
Leaving the U.S. on (date): **_____ _____**	**Returning to the U.S on (date): _____**	
PURPOSE OF TRAVEL/ TRAVEL CONDITIONS (check all that apply):	**TRAVEL ACCOMMODATIONS (check all that apply)**	
☐ Humanitarian ☐ Vacation ☐ Mission Trip ☐ Visiting Family ☐ Urban ☐ Rural ☐ Both	☐ Hotel ☐Camp/ Tent ☐ Dormitory ☐ Ship ☐ Private Home	

Screening Questions: Most vaccines require ***at least 14 days*** to provide full protection. Please plan accordingly. These questions are used to identify contraindications to vaccines or to malaria prophylaxis. Malarone is the only anti-malaria prescription we provide. If you need Yellow Fever Vaccine and are over age 60, it is advised that you discuss the possible contraindications with your primary care provider. By receiving the vaccine, you are acknowledging that this has been done or you have chosen to forgo this advisement.

ALLERGIES / MEDICAL CONDITIONS	**NO**	**YES**	**N/A**
1. Are you allergic to any medicines? Please list:			
2. Are you pregnant or contemplating pregnancy?			
3. Are you breastfeeding?			
4. Are you currently using a birth control method? If yes, what method?			
5. Have you had a severe reaction to a vaccine or vaccine component in the past? Which Vaccines: _____			
6. Are you taking any medications? Please list:_____			
7. Do you have any medical conditions? Please List:_____			
PLEASE ANSWER THE FOLLOWING BY MARKING NO, YES OR DON'T KNOW.	**NO**	**YES**	**DON'T KNOW**
1. Do you have any allergies to latex, eggs, egg components, or gelatin?			
2. Are you immunosuppressed due to HIV, cancer (or cancer medication) organ transplant, thymic disease, generalized malignancy, corticosteroid therapy, alkylating drugs, antimetabolites, or radiation?			
3. Do you have a history of thymus disease or condition such as thymoma, myasthenia gravis, or DiGeorge Syndrome or had your thymus removed?			
4. Do you have any allergy or sensitivity to protamine sulfate?			
5. Have you been recently diagnosed with thrombocytopenia?			
6. If traveling to a malaria-infested area, are you interested in getting a prescription for malaria pills?			
7. Have you taken Malarone before? If yes, please list any reactions or sensitivity: _____			
8. Are you going to be taking Rifampin/Rifabutin, Warfarin (or other anticoagulants), Reglan, Indinavir, or Tetracycline while traveling?			

This screen is not complete without immunization records. Send copy of immunization record with form.

PATIENT SIGNATURE: _____ DATE: _____

The foreign travel service costs $50. Payment is due the day of the appointment. Vaccine costs are separate. HCDPH Foreign Travel Patient Record 11/23

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Name: _____ **Date of Birth:** _____ **Age:**____

FOR OFFICIAL USE ONLY
Date received: _____
Reviewed by:_____
Phone #_____
Date Call Returned to Patient: _____
_____

PATIENT QUESTIONNAIRE NURSE REVIEW Insurance_____
Travel when:_____
Where:_____
_____
Appt Date/Time:_____

Immunization Plan (Recommended/ Required by CDC**)**

Recommended	Vaccine	Dose #1	Dose #2	Dose #3	Declined
	Hep A	_____	_____		
	Hep B	_____	_____	_____	
	Hep A and B Twinrix	_____	_____	_____	
	J. Encephalitis: Order Date: _____	_____	_____		
	MMR (Born after 1956)	_____	_____		
	Meningitis ACWY or B	_____			
	Polio/IPV	_____			
	Rabies	_____	_____	_____	
	Td/Tdap	_____			
	Typhoid	_____			
	Yellow Fever (> 60 yrs, discussed with PCP)	_____			
	COVID	_____	_____	_____	
	Varicella/Shingles	_____	_____		
	Flu	_____			
	Pneumonia	_____			

Chemoprophylaxis Recommended per CDC _____ Malaria Sensitive to Atovaquone Proguanil Hcl (Malarone) _____

Screen for Contraindications:

Has patient been sick or running a fever? _____

Allergies: _____

Current Medications: _____

_____

Medical Conditions: _____

_____

Drug interactions (drugs.com) and contraindications reviewed for Malarone and none identified. _____

NOTES:

_____

Anti-malaria Prophylaxis	Contraindications	Instructions	Possible Side Effects	Prescription
Malarone (Atovaquone, Proguanil)	Contraindicated with severe renal impairment Contraindicated for women who are pregnant or breastfeeding and children less than 11 kg.	Begin taking 1-2 days before travel. Take same time each day and continue for 7 days after return.	Nausea and vomiting, stomach pain, headaches.	Rx Date: _____ Start Date _____ No. Tablets _____ Instructed in use. No Refills Child's Weight:

For situations or conditions not covered by Standing Order, refer to physician.

CDC Recommended Education Provided:

Risk Factors: _____Precautions: _____General Travel Tips: _____Food and Water: _____

Frequent Traveler/Assessment Waived: _____

Nurse Signature: _____ **Date:** _____

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